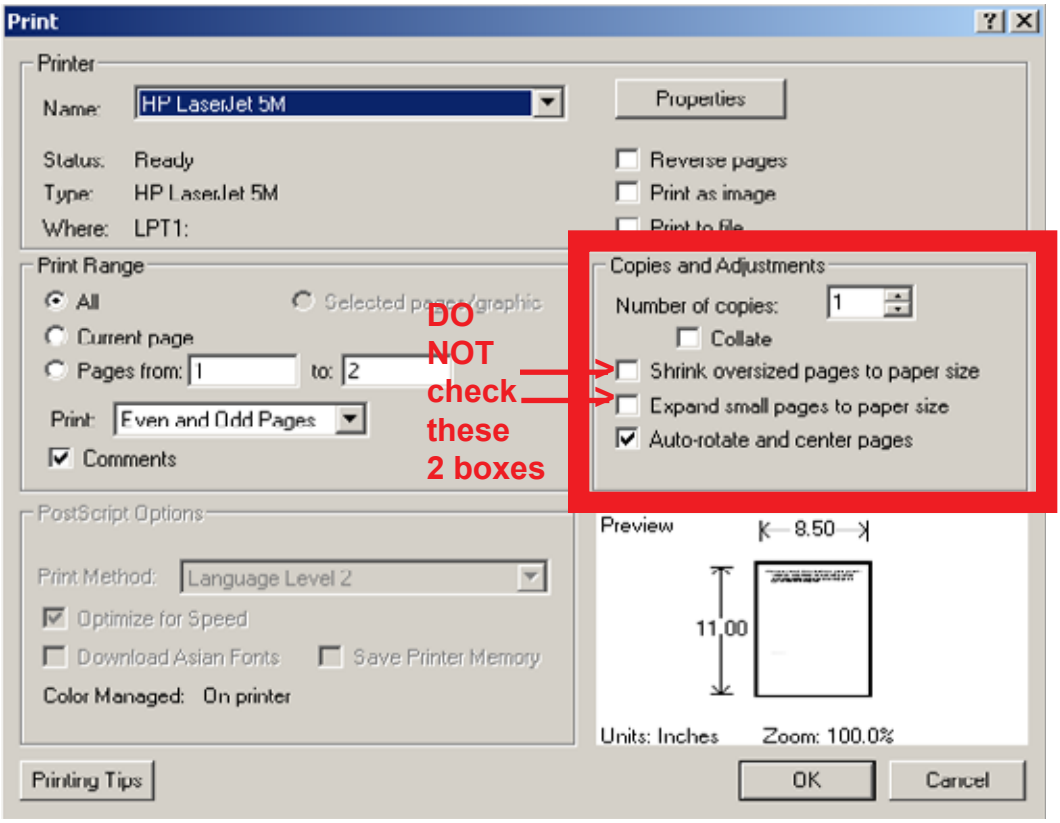
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (7/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Prosthetist Credential Activation Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Prosthetist—Expired

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 677-015 (REV 7/2006)

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Application For Expired Prosthetist Credential Activation

Instructions

When your application for expired credential activation is received by the Department of Health, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment. Your cooperation is requested to permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ Pay **$20.00** Current Renewal Fee. **(All fees are non-refundable)**
- ☐ Pay **$ 75.00** Late Penalty Fee. **(All fees are non-refundable)**
- ☐ Pay **$ 75.00** Expired Credential Reissuance Fee. **(All fees are non-refundable)**

  Total **$170.00** Check or money order made payable to The Department of Health

- ☐ **Box #1 Demographic Information.**

  Name: Please list your current name with middle initial.

  Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

  Telephone Number: Enter current telephone number where you may be reached during normal business hours.

  Social Security Number: Required for licensure by 42 USC 666 and Chapter 26.23 RCW.

  Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

- ☐ **Box #2 Previous Credentialing.** List ***all*** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.
- ☐ **Box #3 Professional Experience.** In chronological order, list all professional work experience since your Washington State credential has expired. If you need additional space, attach on a separate piece of paper.
- ☐ **Box #4 AIDS Education and Training Attestation.** Required by WAC 246-12-040.
- ☐ **Box #5 Criminal and Disciplinary Action Attestation.** Required by WAC 246-12-040. **The Department does criminal background checks on all applicants.**
- ☐ **Box #6 Applicant's Attestation.** Required to be signed and dated in order to process the application.

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE #	ISSUANCE DATE

CREDENTIAL #

Application for Expired Prosthetist Credential Activation

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change.

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)	MAIDEN NAME
☐ Female ☐ Male	/ /		

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list other name(s)

2. Previous Credentialing (Since Last Being Credentialed in Washington State)

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

3. Professional Experience

	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

4. AIDS Education and Training Attestation (Check Appropriate Box)

I certify I have completed the minimum of: ☐ four (4); or ☐ seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

5. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

The Department does criminal background checks on all applicants.

APPLICANT'S INITIALS

6. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Official Use Only

Washington State Records Center

_____
SIGNATURE OF APPLICANT

_____
DATE